



# **STATEMENT**

**of the**

**American Medical Association**

**for the Record**

**United States Senate**

**Committee on Veterans' Affairs**

**Re: Pending Legislation: Improving the Veterans' Choice  
Program**

**S. 2646, Veterans Choice Improvement Act of 2016**

**S. 2633, Improving Veterans Access to Care in the Community  
Act**

**March 15, 2016**

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**S. 2646, Veterans Choice Improvement Act of 2016**

**S. 2633, Improving Veterans Access to Care in the Community Act**

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The American Medical Association (AMA) appreciates the opportunity to submit this statement for the record with regard to the Senate Committee on Veterans' Affairs' hearing today on draft legislation, S. 2646, the "Veterans Choice Improvement Act of 2016," which was introduced by Senators Burr, Tillis, Boozman, and Moran, and S. 2633, the "Improving Veterans Access to Care in the Community Act," which was introduced by Senators Tester, Blumenthal, and Brown. The AMA is strongly committed to helping Congress and the Department of Veterans Affairs (VA) ensure the comprehensive delivery of, and timely access to, primary and specialty health care for our nation's veterans. The AMA was an early supporter of the Veterans Access, Choice, and Accountability Act of 2014 (VA Choice Act), which created the Veterans Choice Program (VCP), and we applaud the Committee's ongoing efforts to reform and improve our nation's veterans' access to quality health care, as well as enhance the ability of non-VA physicians and other providers to deliver such care.

**Consolidation of Programs**

We agree with the VA and the Committee that the VCP has not been working as intended, and we strongly support provisions in both S. 2646 and S. 2633 to consolidate the VCP and all existing community care programs into one streamlined program. While the VA has the legal authority to send veterans outside of the VA for care, there are multiple programs, contracts, laws, and regulations. We think that the poor response to the existing VCP has in part been due to confusion by veterans and physicians between the VCP and the other existing community care programs, such as the Patient-Centered Community Care (PC3) Program. Streamlining and consolidating the different programs would improve care by creating efficiencies and eliminating duplication and costs in administering the new VCP, especially with regard to billing, the reimbursement process, eligibility criteria, and clinical and administrative systems.

## Veterans' Access to Specialty Care

Veterans have had longstanding issues with access to specialty care outside VA facilities. The VA Choice Act, S. 2646, and S. 2633 include the same problematic provisions with respect to veterans' eligibility for specialty care—the requirement that the veteran must live more than 40 miles driving distance from a VA medical facility, including “a community-based outpatient clinic.” This has been interpreted by the VA in some instances as preventing a veteran from going to a facility or physician further away for specialty care, because a VA community-based outpatient clinic is within 40 miles, even if it does not provide the specialty care needed. While S. 2646 includes new language acknowledging that such facilities must have a full-time primary care physician, we recommend that the language also include a reference to necessary specialists.

## Agreements/Contracts with Providers

In order to be effective, the VA's partnerships with private physicians in the community need to be simple and easy to navigate for physicians. We believe that the most straightforward way to authorize care and services by non-VA physicians is through provider agreements, similar to those used in the Medicare program, as recognized by the provisions in the VA Choice Act that created the VCP. Section 101(d)(3) authorizes the VA Secretary to enter into an agreement with non-VA providers using the procedures, including those procedures related to reimbursement, available for entering into provider agreements under the Social Security Act.

It is also extremely important that, under such agreements, physicians and other providers are only subject to the same rules and regulations as Medicare and Medicaid providers. Generally, federal contractors delivering supplies or services of \$10,000 or more to a federal entity have affirmative action obligations as prime contractors pursuant to Executive Order 11246, the Vietnam Era Veterans' Readjustment Assistance Act of 1974, and section 503 of the Rehabilitation Act of 1973. Each government contractor with 50 or more employees and \$50,000 or more in federal contracts is required to develop a written affirmative action plan, which must be updated annually. In addition to complying with multiple layers of affirmative action regulations, federal contractors must comply with and prepare for the prospect of audits conducted by the Office of Federal Contract Compliance Programs (OFCCP). Medicare and Medicaid providers are not considered to be federal contractors subject to these rules and procedures. Moreover, the VA Choice Act waived the OFCCP federal contracting requirements for physicians and other providers entering into contracts and agreements to provide care and services, and we believe that any legislation to improve the VA Choice Program should do so as well. Without such protection, physicians in small private practices could be discouraged from entering into agreements to care for veterans. Accordingly, we support the provision in S. 2646 providing that any contract entered into with non-VA providers for the care of veterans “may not be treated as a federal contract for the acquisition of goods or services and is not subject to any provision of law governing federal contracts for the acquisition of goods or services” (Section 101(d)(1)(C)).

## Billing and Reimbursement

With respect to reforming the VCP's billing and reimbursement processes, we generally support the provisions in S. 2646, except as noted below. According to the VA, "The current VA claims infrastructure and claims process are complex and inefficient due to highly manual procedures, and VA lacks a centralized data repository to support auto adjudication" (U.S. Department of Veterans Affairs, Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care," October 30, 2015, at page 49). The VA has more than 70 centers processing claims across 30 different claims systems, and limited automation with paper-based processes that result in late and incorrect payments. Improving the VA's reimbursement processes would alleviate some of the complaints that physicians and other providers have had tied to the VCP, e.g., administrative hassles and delays in payment. Some of these problems have arisen with Health Net, one of the VCP managers, particularly with respect to billing and reimbursement delays in the New England region. Moving toward auto-adjudication and away from requiring medical records for reimbursement—a current VA requirement—should help to improve claims processing accuracy and predictability and allow claims to be paid promptly, thereby providing an incentive for physicians to join and remain in the provider network.

We appreciate that both S. 2646 and S. 2633 include provisions requiring prompt processing and payment of claims. While we prefer the time frames for processing and payment of claims in S. 2646, which are shorter than in S. 2633, we would note that with respect to clean claims submitted electronically, it should not take 30 days to reimburse a physician. Accordingly, we urge that this provision be changed to 14 days. Further, clean electronic claims should be paid within 30 days.

In addition, while the AMA encourages the use of electronic claims, we do not support mandates on physicians or timetables for submitting all claims with no exceptions, and therefore we cannot support section 103(b) of S. 2646. We note that although most Medicare claims are electronically submitted, there are certain exceptions allowed under Medicare, such as for claims from small providers (e.g., defined as providers with less than 25 full-time equivalent employees (FTEs) that are required to bill a Medicare intermediary, or physicians with fewer than 10 FTEs that are required to bill a Medicare Administrative Contractor), and for claims from providers that submit fewer than 10 claims per month on average during a calendar year. Accordingly, we urge that the mandate provision in S. 2646 be deleted; at the very least, exceptions similar to those recognized by Medicare for small providers should be considered.

Both S. 2646 and S. 2633 would standardize provider reimbursement rates to Medicare rates. While we think that this is moving in the right direction in terms of basing payment to providers on Medicare rates, the AMA supports the Medicare rate as a floor, not a ceiling, especially in areas where there are significant needs for service and limited available specialists. We appreciate that S. 2646 allows some regional variation, for veterans in highly rural areas, in Alaska, and in a state with an all-payer model agreement, but would urge more flexibility be allowed where needed, recognizing the varying expense of clinical practice in different geographic regions of the country.

## Tiered Networks

We are very concerned with the language allowing tiered networks in S. 2633, and therefore support the language in S. 2646 banning such networks for veterans receiving care from non-VA physicians. In its proposal for reform of the VCP, the VA indicated that they intended to provide veterans access to a tiered, “high-performing network,” which would reward providers for delivering “high-quality care” while promoting veteran choice and access. The VA indicated that it would apply industry-leading health plan practices for the tiered network design and that providers in the Preferred tier, versus the Standard tier, must “demonstrate high-value care” in order to be considered in the Preferred tier and to receive higher payment. It is unclear, however, how “high-value care” would be determined or demonstrated. Given some of the access issues that have arisen with the narrow networks offered in the exchanges under the Affordable Care Act and outside the exchanges, we believe that both the VA and the committee need to proceed carefully in moving towards tiered networks. We are concerned that any tiering or narrowing of the networks in a reformed VCP will further exacerbate or create access problems. This is already occurring in certain states, in exchange plans and Medicare Advantage plans, with patients unable to find physicians in the top tiers in their areas or able to receive necessary specialized services because the tiering is specialty and not service or subspecialty specific. With many veterans requiring specialized services, such as mental and behavioral health care and orthopedics, which are already very limited in many places throughout the country, further tiering seems incompatible and actually in conflict with the direction of a reformed VCP program to provide greater and faster access to specialty care services in the community. Narrowing or tiering will do little to demonstrate confidence in the program and could deter participation by physicians in the community. If a prime goal of reforming the VCP is to increase participation and encourage “high-value” or “high-quality” physicians to participate in the program, this tiering will likely have the opposite effect.

## Using Value-Based Reimbursement Models

We are strongly opposed to any use of a value-based payment model (VBM) “to promote the quality of care,” as S. 2633 proposes for incorporation into agreements to provide care by non-VA providers. The VBM is currently incapable of accurately and equitably measuring and comparing the cost and quality of services provided by physicians. A number of the cost and outcome measures that are being used were created for hospitals and are inappropriate for use in physicians’ offices with smaller and less heterogeneous patient populations. Several reports done for the Centers for Medicare & Medicaid Services suggest that practices with the sickest patients fare poorly under the VBM. There are problems with many aspects of the methodology, including risk adjustment attribution and communication of rules and results to physicians. We believe that more analysis and evaluation of the VBM and its underlying physician feedback reports is needed, and oppose its extension to other programs, such as the VCP.

## Conclusion

The AMA, on behalf of our physician and medical student members, is committed to helping ensure that our nation’s veterans receive comprehensive, timely, high-quality care. We applaud the Committee for its dedication to our nation’s veterans, and look forward to working with you

to advance proposals to improve the Veterans Care Program and the care delivery experience for our veterans.